



## Flexible Spending Account Enrollment Form

### Program runs September 1, 2016 through August 31, 2017

Client TASC ID: 4502-8869-1115

**CITY OF TAUNTON**  
**Human Resources Department**  
 141 Oak Street  
 Taunton, MA 02780  
 508-821-1060

**Every line must be completed. Please enter zero (0) on the lines where no amount is being deducted. Make sure to sign and date the enrollment form. Return the completed and signed form to your employer.**

**Forms must be returned to HR by April 25<sup>th</sup>**

**PAYROLL GROUP:**  20 bi-wkly. Teachers  52wk. Admin/Custodians  36wk. Secretaries/Aides/Cafeteria  
[For 52 week employees, only 50 deductions are taken]

**Participant Information:**

Full Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Email \_\_\_\_\_  
 Telephone # \_\_\_\_\_

**Benefit**

	<b>Maximum Allowed</b>	<b>Plan Year Election Amount</b>
Medical (Out-of-Pocket) Expenses	\$ 2,550.00	\$ _____
Dependent Care Expenses	\$ 5,000.00	\$ _____

**AUTHORIZATION:** I certify the above information to be true to the best of my knowledge and that the children for whom I will be claiming dependent or child care expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I agree to have my compensation reduced by the deductible amount(s) stated above. I understand that any amounts remaining in my account(s) not used for qualified expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the Flexible Spending Amount will be in effect for the entire plan year and cannot be revoked except as permitted by federal law. I understand that my share of eligible group premium(s) automatically will be deducted before taxes. I also understand, that if I do not wish to take advantage of having my eligible insurance contributions deducted pre-tax and prefer to be taxed on these dollars, I will contact my payroll department.

Authorized Signature \_\_\_\_\_ Date: \_\_\_\_\_

**Enrollment Form Instructions:**

**Medical (Out-of-Pocket) Expenses:** This amount is usually paid toward deductible and co-insurance portions of health insurance, dental expenses, orthodontic expenses, eye care and other miscellaneous health care expenses per year. After determining the per payroll amount, multiply that number by the number of payrolls to determine your annual election.

**Dependent Care Expenses:** Amount paid for day care expenses per year. The maximum allowable amount under IRS regulations is \$5,000 per calendar year per family; \$2,550 per calendar year for married individuals filing single. This limit is regardless of the number of dependents you may have.